

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039101

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

146
FILED NOV 7 1962

Primary Registration District No.

3026

Registrar's No.

521

STATE FILE NUMBER

VS 300
Rev. 4/59

1 7005

2 7005

3

4 0

5 1

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7 1

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12 1-0

13 1-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 3 Days	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence San. & Hospital		d. STREET ADDRESS (If outside, give location) 1331 South Osage	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle L Last Kraus		4. DATE OF DEATH Month Oct Day 20 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept 14 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Blue Valley Foundry	9. AGE (last birthday) 63
11a. FATHER'S NAME John Edward Kraus		11b. BIRTHPLACE (City and state or country) Alta Vista Kansas	
13a. FATHER'S NAME John Edward Kraus		13b. MOTHER'S MAIDEN NAME Vida Kraus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Vida Kraus		17. ADDRESS 1331 South Osage	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Basilar Artery Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 72 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Independence	
20g. COUNTY Missouri		20h. STATE Missouri	
21. I attended the deceased from 1958 to present and last saw him alive on 10/28/62 Death occurred at 8:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE E. H. Holton MD	
22b. ADDRESS 10901 Whinnier Rd Independence Mo		22c. DATE SIGNED 10/30/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 1, 1962	23c. NAME OF CEMETERY OR CREMATORY Mound Grove Cemetery	23d. LOCATION (City, town, or county) Independence Missouri
24. FUNERAL DIRECTOR Roland R. Speaks Funeral Home Independence		25. DATE RECD. BY LOCAL REG. 11-1-62	
26. REGISTRAR'S SIGNATURE Alba L. Craig		26. REGISTRAR'S SIGNATURE Alba L. Craig	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SEP 5 1963

Nov. 1, 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.